Critical Condition:
The State of the Union's Health Care
2006

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Executive Summary

Our health care system must be reformed.

The United States leads the world in medical research, our hospitals use 21st Century medical technology and we are blessed with having the best doctors, nurses and providers. Soaring costs, however, are putting health care out of reach for more and more families and employers. To deal with this problem, policymakers have focused on dealing with "who" pays for the care. This approach, unfortunately, does not deal with the root causes of cost increases. The doctor/patient relationship has been divided by a wall of paperwork, inefficiencies, and errors leading to massive expenses. Fixing the system is not about "who" is paying, it's about "what" we are paying for. A broken system is not fixed by shifting payment to families, employers or taxpayers. Affordability must begin with fundamental reforms to quality and accessibility.

The rising costs of the current health care system are staggering. Both public and private health care spending now exceeds $2 trillion annually, with health care costs consuming 16 percent of the nation's total economic output or gross domestic product.[1] In fiscal year 2005, the federal government spent over 45 percent of its mandatory spending on health care programs. That translates to *half a trillion dollars* in taxes.

Per capita national health care expenditures doubled over the last fifteen years from $2,821 to $6,280 last year.[2] "The cost to employers of providing comprehensive health benefits has risen 57 percent in five years, to an average of $5,646 for each of their

1 Centers for Medicare and Medicaid Services. Continued Slowdown in Health Care Cost Growth Projected in 2005 and 2006. February 22, 2006.
2 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip). 2004.

employees,"[3] and a family of four pays an average of $12,000 in out-of-pocket costs.[4] Such health care costs also add to overhead for American businesses reducing their ability to compete in the international marketplace.

Although the often quoted claim that 45 million Americans are without health insurance has been questioned, what is certain is that many families do not carry health insurance, many avoid early treatment, and many seek out expensive care in the emergency departments of hospitals.

Cost increases are generally attributed to higher rates of chronic illness, increased numbers of people seeking care, and the high costs of medical technology. When chronic illness can be prevented, when care can be managed more effectively, and when the system eliminates unnecessary tests and hospitalizations, quality goes up and costs go down.

This report reviews the impact of these costs on American jobs and families. It also provides an analysis of who the uninsured are, the public and private attempts to control costs, and details some of the greatest challenges facing the nation's health care system today. Although there are many places where reform can take place, this document focuses on ten major contributors to increasing costs, and ten recommendations for Congressional action. In some cases, Congressional action and/or private efforts are already underway; in other cases bills have been introduced but not yet passed. In all cases, Congress and the private sector have the ability to act that would literally save tens of thousands of lives and hundreds of billions of dollars.

The ten areas of reform are: 1) improving primary prevention; 2) reducing health care infection rates; 3) expanding access to community health centers; 4) increasing transparency of information within the health care system; 5) improving the accuracy of

3 Mercer Human Resource Consulting. Health benefit cost slows for a third year, rising just 6.1% in 2005. November 21, 2005.
4 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip). 2004.

and secure access to medical records; 6) utilizing care management of chronic diseases; 7) removing barriers to mental health care; 8) eliminating defensive medicine; 9) lowering the cost of prescription drugs and 10) reducing obesity. Specific recommendations to reduce errors and improve care are offered for each category.

The actions listed include: vigorous public education, providing funding for implementation of cost saving programs, and mandating greater efficiency. The money Congress will save far outweighs the money spent on these reforms. By keeping in mind these 10 principles for change we can lower health care costs by at least *$300 billion per year*. If these fundamental reforms do not occur, it is clear that costs of health care will continue to increase dramatically over the next decade costing more lives, more money and putting care out of reach of even more Americans. Critical Condition: The State of the Union's Health Care provides a framework for Congressional reform and action.

PART 1:THE COSTS AND CHALLENGES OF HEALTH CARE IN OUR NATION

Introduction

Few things are more valuable to us than the health of our families. When their health is threatened, we feel frightened, vulnerable and search for help. The United States provides the best health care in the world; we have the most dedicated and caring medical professionals, and we have made huge advances in fighting disease and prolonging life. However, despite our many accomplishments, the American health care system is burdened by severe problems that lower quality, increase costs, and make the system unaffordable and inaccessible for millions of Americans. Too many families are only able to window shop for health care coverage, feeling as though they cannot go into the store.

Too many families cannot afford to see their doctor, too many put off early treatment, too many are overwhelmed by hospital bills, too many meet a wall of bureaucracy that stands between them and their doctor. The failure of this system costs tens of thousands of lives and wastes hundreds of billions of dollars.

Despite our incredible advances in medical technology, we maintain a system plagued by preventable errors and diseases. It is a 21st century health care system that is hopelessly bogged down by 18th century paperwork. This antiquated system handcuffs our doctors' ability to treat and cure problems both early and accurately and creates a barrier between doctor and patient. What our nation needs is not a way to pay for health care as it is, but to transform health care into what it needs to be: affordable, accessible, quality health care.

Reforming our health care system means we must focus on improving quality and efficiency, not remain mired in discussions of cost shifting. To date, many "reforms," in health care only concentrates on *who* is paying. What we need is a substantial shift in

what we are paying for. By focusing on several fundamental reforms, the U.S. Congress can implement compassionate changes that will save lives and dollars.

This analysis of the state of our union's health care system reviews the challenges our nation faces and presents recommendations on how we can save money and most importantly-lives. It by no means is a comprehensive review of every area where the system can be improved. But it lays out several key goals where Congress could act now to reform health care.

The Price of Health Care

Health care costs are skyrocketing: in fiscal year 2005, the Federal government spent over 45 percent of its mandatory spending on health care programs, including $298 billion for Medicare and $181 billion on Medicaid.[5] The states are seeing their budgets for Medicaid increase to an average of 17 percent of state general fund budgets, and increasing at more than twice the rate of inflation.[6] This nearly *half a trillion* dollars does not even include the billions in discretionary health care spending for the Department of Veterans Affairs ($31 billion), the National Institutes of Health (which has increased over 100 percent in the last 10 years to $28.5 billion), the Centers for Disease Control and Prevention ($8.2 billion), the Indian Health Service ($4 billion), Early Head Start ($6.8 billion) and the Women, Infants and Children program ($5.3 billion).[7] Add this to the average of $5,000 paid for by employers per employee,[8] and the average of $12,000 paid out-of-pocket by a family of four across this nation.[9]

In January 2006, the Centers for Medicare and Medicaid Services (CMS) reported that the overall cost of health care doubled from 1993 to 2004 (including insurance, hospital and doctor fees, medicine, medical supplies, nursing home and home health care). This

5 Office of Management and Budget. Historical Tables. Budget of the United States Government. Fiscal Year 2007.
6 National Center for Policy Analysis. Medicaid: Daily Policy Digest. February 20, 2006.
7 U.S. House Committee on Appropriations. FY 06 Appropriations Funding. 2006.
8 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip). 2004.
9 Ibid.

amounts to a $140 billion dollar increase from 2003 to 2004 (an increase in that year alone of 7.9 percent at a time when the inflation rate was 2.7 percent).[10] During that time, the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services reported that overall quality of care had only improved at a rate of 2.8 percent from 2003 to 2005.[11]

In February 2006, actuaries at CMS reported that by 2015, health care spending will account for one in every five dollars, or 20 percent of gross domestic product, up from 16 percent today. Health care spending by federal and state governments will then equal 50 percent of their budgets. Similarly, overall healthcare costs will increase an average of 7.2 percent a year. Specifically, by 2015, CMS projects that:

- Medicare costs per year will more than double from $298 billion today to $792 billion; and
- Medicaid spending per year will *triple*, growing from $181 billion to $670 billion.[12]

It is estimated that Medicare will be bankrupt by 2019, seven years earlier than previously expected and 23 years earlier than Social Security.[13]

Medicaid, which covers 50 million people and costs nearly $300 billion in shared revenues, is facing serious financial problems on both the state and federal level. "Medicaid now consumes 22 percent of the average state budget and in many states is a larger share of spending than elementary and secondary education. Between 2002 and 2005, 38 states reduced eligibility and 34 cut benefits." [14] Medicaid has been criticized as an inefficient system that has not seen any comprehensive reform since its inception in 1964. The Medicaid program is designed to provide medical care to children, parents,

10 Centers for Medicare and Medicaid Services. Health Care Spending Growth Rate Continues to Decline in 2004. January 10, 2006.
11 Agency for Health Research and Quality. AHRQ Releases 2005 National Healthcare Quality And Disparities Reports. January 9, 2006.
12 Borger, Christine. Health Spending Projections Through 2015: Changes On The Horizon. Health Affairs. February 28, 2006.
13 Social Security and Medicare Board of Trustees. Status of the Social Security and Medicare Programs. Updated March 2005.
14 Barton, Joe. Save Medicaid from Itself. The Washington Times. October 31, 2005.

pregnant women, the disabled and long term care to seniors. Since its inception new diagnoses, tests and treatment procedures have been discovered. Each time Medicaid has made coverage changes, however, it does so via "waivers" that alter or amend the original regulations. To date there are over 388 waivers[15] approved or enacted acting like a confusing patchwork quilt of coverage. Because of the burdensome paperwork, payment levels and regulatory confusion, 50 percent of physicians do not accept all new Medicaid patients.[16]

In addition to the basic medical costs of Medicaid, states have re-cycled federal funds to appear as matching funds that in turn are leveraged into more federal dollars. Middle and upper income families have found ways to get Medicaid to pay for long term care by hiding their financial assets. This in turn has served as a disincentive for seniors to purchase their own long term health care insurance. Although Congress has recently acted to close these loopholes, the costs to the taxpayers have been in the billions of dollars.

Family spending on health care is also increasing. In just one year, from 2004 to 2005, the medical costs for a four-person household increased by 9.1 percent to $12,214. While health care costs varied by age in 2004, the most recent year for which data is available, per capita expenditures for health care were $6,280, more than double the $2,821 costs in 1990.[17]

Increases in health insurance premiums are how most consumers and employers experience spiraling costs. After four consecutive years of double digit increases from 2000 to 2004 premium rates declined slightly in 2005 to 9.2 percent. By comparison, workers wages increased an average of 2.7 percent and inflation rose at 3.5 percent in 2004 and at 9.2 percent in 2005. Added together over the years, the total increase in

15 Centers for Medicare and Medicaid Services. Medicaid State Waiver Program Demonstration Projects. 2006.
16 Cunningham, Peter. Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001.Center for Studying Health System Change. December 2002.
17 Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip). 2004.

premiums reaches 73 percent since 2000. For families where employers pay the average of 74 percent of premium costs, this increase translates to an average increase of $1,094 over the past 5 years. Annual per family cost ($10,880) now exceeds gross minimum wage earnings for a full time worker ($10,712).[18]

The Uninsured

Millions more are covered through a variety of federally funded programs providing health care for our most vulnerable. Medicaid covers the low income and disabled, Medicare covers the elderly and the Veterans Administration provides coverage for veterans. It is frequently reported that 45 million Americans, however, are without any health insurance in a given year.[19] Some use this as a measure of the urgency to extend health care coverage. Others cite it as a barrier to expanding health care coverage citing huge costs associated with that number. There are substantial questions, however, as to the accuracy of that statistic. Accurate information is necessary if the federal government is to respond effectively.

Among those 45 million "uninsured," nearly 15 million live in households where their annual income exceeds $50,000. Of those, 7.6 million have incomes in excess of $75,000 according census data form 2003.[20] One could conclude that many people at these income levels are able to obtain insurance in most states but choose not to. Another important point is that 18 million of the uninsured are between the ages of 18 and 34. Historically, many in this age bracket have voluntarily chosen not to carry insurance because of their youth and higher chances of good health. They often opt out of health care coverage voluntarily choosing to keep any premiums, and assume they will have no need for health care. Many who are between jobs or starting new jobs are often counted as uninsured when in fact they will be picked up when starting a new job, or when the next enrollment

18 Kaiser Family Foundation. Survey Finds Steady Decline in Businesses Offering Health Benefits to Workers Since 2000. September 14, 2005.
19 Tallon, James. The Uninsured: A Primer. Kaiser Commission on Medicaid and the Uninsured. January 2006.
20 Meir, Conrad. Analysis: Politicians Using Flawed Data on Uninsured Population. The Heartland Institute. December 2004.

period begins for the new employees. Data from the U.S. Census also tells us that when a family loses their health insurance it is on average for a period of 5.6 months.[21]

The rates of "uninsured" is inflated among low income and disabled adults and children. Many are eligible for Medicaid and the state's Children's Health Insurance Programs (SCHIP) but are not enrolled.[22]

"CMS reported 2 million people became eligible for Medicaid in 2003, but the Census Bureau recorded only a 350,000 increase in Medicaid enrollment during that year."[23] "If they have not used covered services recently…many people may not be aware that they or their children are covered by a health insurance program, either private or government"[24] sponsored. Thus when counting those without insurance coverage, many may not be aware that they actually are covered. "However, as soon as a person who is eligible for Medicaid but is not currently enrolled enters the health care system through a hospital or clinic", that person "is automatically enrolled into the Medicaid plan."[25]

Overall, it appears that the reference to "45 million" is an overestimate of the numbers of uninsured in America. Actual numbers are likely several million below this level. When interpreting the cost of any private or government sponsored health care, a more accurate analysis of the uninsured is needed. Regardless of the exact number, it is still evident that many forgo insurance because of costs or lack of awareness of available programs. Many of these may choose a "pay for services" approach to handling their own direct costs when needed. But for those who are uninsured it is appropriate to review added costs when they delay early treatment, or later seek care in more expensive emergency rooms. In either case, costs are not controlled, but are increased, especially when the burden is shifted to taxpayers or passed on as a hidden cost to those who carry insurance. In a nation that spends such a large portion of its Gross Domestic Product (GDP) on health

21 U.S. Census Bureau. Dynamics of Economic Well-being: Health Insurance 1996-1999. Report No. Pgs. 70-92. August 2003.
22 Meir, Conrad. Analysis: Politicians Using Flawed Data on Uninsured Population. The Heartland Institute. December 2004. Pg. 1.
23 Ibid.
24 Ibid.
25 Ibid.

care, we must be able to find ways to make health care and health insurance more affordable and accessible to those who need it rather than continue a pattern of cost shifting.

PART 2: ATTEMPTS TO FIX THE PROBLEMS OF COSTS

Federal Attempts to Control Health Care Costs

The federal government has made several attempts to keep costs from rising rapidly among its Medicaid, Medicare and VA programs. Among these actions are: targeting waste fraud and abuse, expanding cost sharing, and reforms of factors that drive expenses.

When reviewing federal governments attempt to control costs, the reader should note Congress relies on the Congressional budget office (CBO) to provide estimates of government (taxpayer) costs for government programs. The CBO "scores" programs based upon their estimates of the total government costs for implementing programs. The CBO does not provide scores for savings from prevention, early treatment or other attempts to prevent increases in spending, calling these "dynamic" costs. Thus, the federal government ties its own hands when looking to analyze savings from reforms. It simply does not do it.

For example, the CBO tells Congress what it would cost to provide a public education program to reduce smoking. It is not able to provide information on how much money would be saved if people reduced or stopped smoking. Additionally, when reviewing the cost of emergency care CBO can report $41 billion spent on uncompensated care annually to the uninsured for which the patient and/or the payer either was not billed or failed to pay.[26] Many of those seeking emergency care were for non-emergencies. Since the law requires emergency departments to treat anyone who seeks care, hospitals list the unpaid fees as "uncompensated care." In addition, while Community Health Centers are funded to provide alternatives for seeking non emergency care, the CBO can only score what those centers will cost, but it is unable to score the potential savings from reductions in emergency room care for non emergencies and unnecessary doctor visits from receiving preventive care at a Community Health Center.

26 Kaiser Commission on Medicaid and the Uninsured. The Cost of Care for the Uninsured: What Do We Spend & Who Pays? May 2004.

Waste, Fraud and Abuse

Over the years, there have been several reports of major abuses with federally funded health care programs. Consider these recent reports from just one state:

- In New York State, at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 - 30 percent more were siphoned off for abuse for over $18 billion a year.
- In New York, a Brooklyn dentist claimed to have performed as many as 991 procedures a day on Medicaid patients for $1 million in fraud.
- Also in Brooklyn, a doctor prescribed $11.5 million worth of an expensive muscle-building drug intended for AIDS patients that was then diverted to bodybuilders in a criminal scheme.[27]

The recently passed Deficit Reduction Act seeks to eliminate over billing, fraudulent claims and misuse of Medicaid funds. The Deficit Reduction Act establishes a Medicaid Integrity program to audit state Medicaid claims and identify overpayments to individuals or entities receiving federal funds and a Medicare-Medicaid Data Match Program to eliminate double-billing. Staff and funding for the Medicaid's Office of the Inspector General will also be increased by $25 million for these efforts. The bill also bans anyone with more than $500,000 in home equity from Medicaid eligibility altogether. Where states have higher home values they would be allowed to raise that level to $750,000.

Similar abuses could be found under Medicare. Fraud and administrative errors amount to over $12.3 billion annually**.** The Inspector General at CMS has settled 19 cases of contractor fraud in recent years, with a maximum settlement of $76 million.[28]

An investigation in the Veterans Administration found it was paying out millions of benefits to veterans who were fugitives from the law. The Inspector General's Office of

27 Levy, Clifford. New York Medicaid Fraud May Reach Into Billions. The New York Times. July 18, 2005.

28 Corrigan, Dana. Testimony before the U.S. House of Representatives Committee on the Budget on Fraud, Waste, and Abuse in the Medicare and Medicaid programs. Acting Principal Deputy and Inspector General. U.S. Department of Health and Human Services. July 9, 2003.

the U.S. Department of Veteran's Affairs recently instituted a system matching fugitive felon files of law enforcement organizations with VA benefit and personnel records. Once a veteran or employee is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant to assist in apprehension. Results of a pilot program have discovered that this fugitive review system will save the VA about $209 million.[29]

Cost sharing

Recent attempts to control costs have included granting permission for states to limit benefits or to increase premiums, deductibles, and co-payments. For example, the FY 2007 budget request for Medicare proposed premium increases on seniors with annual incomes of more than $80,000. The Office of Management and Budget estimates these premium increases will save $40 million over the first five years through offsetting costs. In addition, a proposal for veterans care projected annual savings of $795 million in 2007 by proposing higher co-payments for prescription drugs and a new fee to receive government-sponsored health care on middle-income veterans who incurred no military service-related disability. Congress has repeatedly opposed these proposed increases in veterans' costs in recent years. As for Medicaid, the Deficit Reduction Act of 2005 allows states to impose higher cost-sharing requirements or co-payments on families that may not exceed 5 percent of the family income. The Congressional Budget Office (CBO) estimates cost-sharing will save $10 billion over the next ten years.

The Medicare Drug Discount Program

In 2003, Congress passed the Medicare Modernization Act, which provides a comprehensive Medicare prescription drug benefit with low co-payments for America's seniors to save up to 50 percent on their prescription drug costs. Since the beginning of the enrollment period on January 1, 2006 more than 27 million seniors have signed up for the new benefit with more than 5.3 million in the last three months, including 1.5 million who signed up in the last 30 days. Ten weeks after the start of the new Medicare drug

29 Griffen, Richard. Testimony before the U.S. House of Representatives Committee on Veterans Affairs Haring on Past and Present Efforts to Identify and Eliminate Waste, Fraud and Mismanagement in Programs Administered by the Department of Veterans Affairs. May 8, 2003.

benefit, a survey reported that six out of ten seniors who signed up for the program were saving money.[30]

When the new Part D drug discount plan commenced in January, both the federal government and the private plans were staffed insufficiently to deal with the twenty plus million seniors initially enrolled in the first couple of months. This was exacerbated by problems identifying dual eligible seniors (those on both Medicare and Medicaid who were often automatically enrolled into Part D plans). However, from January to March, both the federal government and the private Part D plans have responded to improve identification of dual eligible seniors. In addition, wait times for pharmacists to identify dual-eligible seniors have been reduced to less than 5 minutes. As of March 2006, a survey of 401 seniors who are dually eligible for Medicare and Medicaid found that 90 percent of enrollees experienced no problems using the new Medicare drug benefit.[31] Although problems are encountered for many seniors as they sign up, Medicare is working to deal with these issues.

Federal Program Reforms

Initiatives are emerging in federal programs that are attempting to control costs through reform.

Care Management: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) establishes a 1 year assessment program for reimbursement to pharmacists for medication therapy management (MTM) programs. These programs manage and monitor patients' drug therapy for chronic conditions such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure to ensure that seniors are taking medications to improve therapeutic benefits and reduce the risk of adverse drug reactions. MTM programs, however, were also not scored by CBO for potential cost savings that may well result from reduced hospitalizations, fewer

30 America's Health Insurance Plan. Most Drug Enrollees Already Saving. March 13, 2006.
31 Ibid.

medication errors, and increased patient compliance with drug regimens for these patients.

AMP and Medicaid: For years Medicaid had been paying for drugs using the Average Wholesale Price (AWP), a reference price printed in commercial price publications by drug manufacturers. AWP has no real empirical basis as a cost indicator. In some cases it saved money, in other cases it did not. Formerly, under the AWP system, the Inspector General of the Department of Health and Human Services reported Medicaid reimbursements exceeded the true costs of pharmacists by $1.5 billion in 2002. For example, Medicaid once paid $5,336 for Fluoxetine (a generic for Prozac) that cost the pharmacist only $88.[32]

The recently enacted Deficit Reduction Act attempts to reform this practice by setting a different rate for medicines based on the Average Manufacturers Price (AMP). AMP is the average net price paid to drug manufacturers by wholesalers. This reference was only previously available to the Centers for Medicare and Medicaid Services (CMS). Under this new law, the AMP will be publicly available for the first time. CBO estimates the AMP will save taxpayers $5.4 billion over five years in overpayments, and could also help private health plans negotiate better drug prices.[33]

Many independent pharmacists, however, have expressed concerns that this reimbursement may not provide sufficient compensation for dispensing prescription drugs. The proposal requires individual states to set dispensing fees; thus states have autonomy to decrease fees while seeking ways to balance their budgets. A recent study by the American Pharmacists Association uncovered that "the average dispensing cost per prescription is $9.62, but the average dispensing fee paid under Medicaid is less than half that - only $4.15."[34]

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32 U.S. House Committee on Energy and Commerce. 2005.
33 Smith, Dennis. Testimony before the U.S. Senate Finance Committee on Medicaid Abuse. June 28, 2005
34 American Pharmacists Association. Medicaid Payment Reform. January 2006.: Johnsrud, Michael. Et. al. Estimating the Costs of Dispensing Prescription Drugs. Technical Analysis. The University of Texas at Austin. Summer 2005.

Generic Drugs: A 2004 study by the U.S. Department of Health and Human Services stated that "if consumers bought generic products whenever possible it would produce approximately $17 billion in annual savings."[35] There is a dramatic cost difference in generic versus brand name drugs. Average generic drug prices in 2004 was $28.71, while brand name prescription drug costs averaged $95.54.[36] When comparing generics with their brand name equivalent, generics save between 30 percent to 80 percent. Of the 11,167 drugs listed in the Food and Drug Administration's (FDA) price guide 8,400 have generic counterparts.[37] Generic drugs account for only 13.1 percent of every dollar spent on prescription drugs.[38] According to the FDA there is an increasing use of generic drugs. Twenty years ago generics comprised only 12 percent of all prescriptions. Today, that number exceeds 50 percent in the United States.[39]

Title XI of the Medicare Prescription Drug Modernization Act provides for, among other things, limits on certain court actions that could delay availability of generic drugs. This provision is expected to save consumers billions of dollars, in addition to lower costs for government and employer-provided coverage. Under the Drug Price Competition and Patent Term Restoration Act of 1984, also known as the Hatch-Waxman Act, generic drug companies do not have to repeat expensive clinical trials that were previously conducted by brand name drug companies. Also, original patents for brand-name drugs can only be extended by 30 days before they have to compete with generics.

35 U.S. Department of Health and Human Services. Report on Prescription Drug Importation. December 2004.
36 The National Association of Chain Drug Stores. October 2005.
37 FDA's Orange Book. February 2006.
38 Generic Pharmaceutical Association. Statistics. 2005.
39 U.S. Food and Drug Association. Greater Access to Generic Drugs. FDA Consumer Magazine. September-October Issue 2003.

Private Sector Attempts to Control Health Care Costs

A 2005 Employer Health Benefits Survey reported that fewer businesses offer health insurance to their workers today than just five years ago, while the cost of providing coverage continues to outpace inflation and wage growth. The survey which included 2,995 non-federal public and private firms, "found that three in five firms (60 percent) offered coverage to workers in 2005, down significantly from 69 percent in 2000 and 66 percent in 2003." The drop is almost entirely due to a dramatic decrease in the number of small businesses that can afford to provide health benefits.[40]

For employers who offer a health care benefit, on average their costs are five times greater than the employees out of pocket costs.[41] Many employers are expecting a nearly 10 percent increase in health care costs this year. As health care costs now make up 16 percent of the country's economic output, businesses are forced to alter deductibles, co-pays, premiums, and coverage to slow down skyrocketing costs. The rising price of health care also adds to manufacturing costs which makes American businesses less competitive in the international marketplace. For example, health care expenses for General Motors (GM) current and retired U.S. workers add about $1,500 to every vehicle it manufacturers. GM recently increased copays to reduce about $1 billion from the $5.6 billion GM now spends on healthcare costs for union members, retirees, and their families. Despite these changes, GM and other American companies are at a disadvantage in the international marketplace.[42]

Asian automobile manufacturers feature a younger work force and offer their workers far less extensive health plans and provide even fewer benefits to retirees. Consequently, some foreign automobile manufacturers maintain a built-in competitive advantage against American car companies because they are able to sell their vehicles without these

40 Kaiser Family Foundation. Survey Finds Steady Decline in Businesses Offering Health Benefits to Workers Since 2000. September 14, 2005.
41 Freudenheim, Milt. Workers Feel Pinch of Rising Health Costs. The New York Times, October 22, 2003.
42 PBS Online NewsHour. Automaker GM plans to cut 25,000 jobs, close more plants. January 2005.

increased costs. Unless the spiraling increases are changed, U.S. companies will continue to be at a competitive disadvantage in the world.

As overall health care costs have risen, employees' share of those costs have risen as well. A 2003 survey of 300 employers with 5,000 or more workers found that on average, the annual out-of-pocket costs for employees of large companies have more than doubled since 1998, to $2,126 in 2003. Employees' out-of-pocket costs rose from 9.6 percent of the average total cost of employee health care in 1998 to 12.0 percent in 2003. In addition, their premium payments rose from 15.7 percent of costs to 18 percent over the same period.[43]

Employers still pay the bulk of their workers' health care bills, although their contribution slipped from 75 percent to 70 percent of employees' total health care costs from 1998-2003. The same survey found that average employer contribution per employee was $5,000 in 2003, compared with $4,000 in 1998.[44]

In addition, health administration paperwork costs more than $294 billion annually, which is equal to $1,059 per person, or 31 percent of all health care expenditures in the United States.[45] Small firms face relatively high health care administrative costs, and many small-business owners consequently do not see it as efficient to organize insurance.

Precisely because they lack the economies of scale and the management resources of larger firms, small businesses tend to face high costs when administering plans. According to data collected by the CBO, "overhead costs for providing insurance can be more than 30 percent of premium costs for firms with fewer than 10 employees, compared with about 12 percent for firms with more than 500 employees."[46]

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43 Freudenheim, Milt. Workers Feel Pinch of Rising Health Costs. The New York Times. October 22, 2003.
44 Ibid.
45 Woolhandler, Steffie. Costs of Health Care Administration in the United States and Canada. The New England Journal of Medicine. August 2003.
46 Butler, Stuart. Health Care Tax Credits and the Uninsured. The Heritage Foundation. February 13, 2002.

These increasing health care costs are frequently cited as the reasons why so many small businesses do not offer health care benefits.

In order to reduce costs, large corporations are limiting the scope of the health benefits they offer, increasing employee cost-sharing and adopting cost management strategies for their prescription drug benefits. Employers are eliminating retiree health benefits for new hires; reducing coverage for noncritical services; and increasing premiums, co-payments, and deductibles to place greater cost sharing with employees. In addition, companies are utilizing purchasing coalitions to drive down costs, and invoking requirements for pre-approval of services and utilizing tiered formularies for pharmacy benefits.

Purchasing Coalitions: are formed to expand the numbers of people involved in a network. Employers can band together in coalitions to leverage their purchasing power to create greater incentives for quality improvement and cost reductions than can be conveyed by a single entity. This reduces the impact of any one individuals medical bills by including them in a much larger population, thus there is less of an impact of one person among a hundred thousand employees in a whole network versus 25 employees at a specific business.

One program cited as an example of reforming the system is The Leapfrog Group, a purchasing coalition of more than 100 organizations. With goals of medical excellence, improving patient safety, reducing errors and lowering premiums the group has been able to pass on savings to its members. Its reforms are also credited with saving lives.[47]

Preapproval requirements: By obtaining permission from an approved professional reviewer prior to obtaining a service, plans are trying to reign in costs and reduce unnecessary treatments and procedures. Massachusetts largest health insurer is seeking to reduce soaring radiology costs by requiring doctors to receive authorization before scheduling advanced imaging procedures.[48] Such requirements are designed to eliminate

47 Faulkner, Lydia. Managing Health Care Costs: Lessons from the Private Sector. National Governors Association. October 2002.
48 Krasner, Jeffrey. Blue Cross to require preapproval for scans. Boston Globe. September 2005.

unnecessary duplication and to prevent tests that have little or no diagnostic value. Some doctors complain, however, that the preapproval process can delay care and adds to their paperwork burden.

Formularies: Drug "formularies" are used in some employer health insurance contracts to lower costs by, limiting drug coverage to those medications for which lower costs have been negotiated with manufacturers. Thus, if medications X and Y are chemically and/or therapeutically the same, the company may negotiate with a manufacturer for a lower price by having patients take drug Y instead of X.

Medication co-payments: Increasingly, large employers are using co-payments and coinsurance to control costs. Currently, 68 percent of large employers (more than 500 employees) use co-payments to cover the costs of drugs and encourage the use of generics. This includes tiered co-payments where the lowest co-pay is for generic drugs, with higher payments for "preferred" drugs and still larger co-payments for "non-preferred" medication. Several companies with over 20,000 employees now use a specialized pharmacy benefits manager and 35 percent require a co-insurance where the employees share increase with inflation rather than remain a fixed co-payment amount.[49]

Deductibles and co-payments for direct health care: Cost management strategies often involve increasing deductibles and co-payments for hospital and doctor visits. Again, the philosophy here is to share the overall expenses of care, to discourage employees from seeking care when not necessary, and to encourage more healthy lifestyles. About two thirds of plans now require a deductible for hospital expenses. The average office visit co-payment has risen to $18, with higher co-payments for visits to a specialist ($29.00).[50]

Some companies combine a variety of these interventions to encourage employees to participate in cost conscious health care. The food retailer Whole Foods offers an interesting perspective. They offer Health Reimbursement Accounts or HRAs which is a

49 Mercer Human Resource Consulting. Health benefit cost slows for a third year, rising just 6.1% in 2005. November 2005.
50 Ibid.

tax advantaged savings account that employees use to pay routine medical expenses. Each year Whole foods deposits $300 in to these accounts for new employees and up to $1,800 for employees with five years of service. From this account employees pay routine medical expenses and unspent funds roll over into the next year. A high deductible for medical expenses ($1,000) and prescription drugs ($500) are included. But out of pocket spending is capped at $3,500. Only the employer can deposit money in the account and the fund stays behind when the employee leaves.[51]

Health Savings Accounts

Private-sector employers have recently established "consumer-driven" health insurance plans. These plans reduce corporate spending on employee care and create incentives for employees to limit their health care consumption. Consumer-driven plans are designed to make patients more responsible for spending their own health care dollars wisely.

Consumer-driven plans such as Health Savings Accounts (HSAs) limit corporate contributions to a fixed annual amount, set high deductibles, increase consumer responsibility in the selection of care, and often allow the unspent share of the personal or employer contributions to be carried forward for future spending. Thus, consumer-driven plans save money by creating a financial incentive for employees to lower health care spending.

A May 2005 study of health insurance plans offering HSAs reported well over one million people are enrolled in HSAs although this represents a little more than 1 percent of those who are eligible. Much of the recent growth comes from employers offering HSAs to their employees. There has also been dramatic growth in the number of health insurers that sell high deductible plans for HSAs.[52]

51 Pipes, Sally. How Whole Foods Can Help Wal-Mart Beat Scrooge Rap. Pacific Research Institute. December 17, 2004.
52 America's Health Insurance Plans. HSAs More Than Double in Six Months, New AHIP Study Shows. May 4, 2005.

Annual costs for HSA plans are considerably less expensive than preferred provider organization (PPO) plans ($5,480 per year compared with $6,480 for a traditional PPO). Cost increases are also less with HSA accounts (4.7 percent in consumer-driven plans compared to 6.3 percent in PPOs).[53]

However, it is important to note that while HSAs provide an option for some individuals and businesses to lower health care costs, they may not be the best option for everyone. A February 2006 study by the Employee Benefits Research Institute and the Commonwealth Institute found that, "31 percent of HSA participants nationwide paid more than 5 percent of their income in out-of-pocket health care costs and premiums. By contrast, only 12 percent of people with regular comprehensive health coverage spent the same portion on medical care." The same study also found that, "individuals in HSAs and other high-deductible health plans were significantly more likely to avoid, skip, or delay health care because of costs."[54] Yet, it is hoped that by encouraging more Americans to use their cost consciousness powers on the health care system that they will form an ever increasing group that can drive down costs.

Prevention Programs

Employers interested in reducing health care costs and improving the health of their workforce can choose to expand preventive service benefits, such as immunizations, screenings, fitness programs and counseling services to mitigate health risk behaviors. Half of all U.S. deaths from chronic diseases including diabetes, heart disease, and strokes occur as a result of preventable causes, yet more than 95 percent of our health care spending is committed to diagnosis and treatment as opposed to prevention. Providing coverage for preventive services can result in maximized health care dollars spent. It can also help encourage more enrollees to seek preventive services.

53 Mercer Human Resource Consulting. Beyond the early adopters: Consumerism at work in the marketplace. February 1, 2006.
54 Fronstin, Paul. Early Experience with High-Deductible and Consumer-Driven Health Plans. Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. December 2005. : Employee Benefit Research Institute. Survey of Consumer Driven Health Plans Prompts Debate. February 2006.

The U.S. Preventive Services Task Force (USPSTF), an independent panel of experts in primary care and prevention sponsored by the U.S. Department of Health and Human Services, has endorsed a core set of evidence-based preventive services. These services lead to higher employee productivity, lower absenteeism, and stronger organizational commitment from employees.

When the Sunbeam-Oster Company initiated pre-natal mandatory classes for female employees premature births declined. Further, the cost of maternal infant care declined by 86 percent in two years from over $27,000 to less than $4,000 per employee.[55]

Several studies indicated that comprehensive health promotion programs in the workplace dramatically reduce costs. Programs include banning smoking in the workplace, promoting regular exercise, and teaching disease prevention.

Employee fitness programs have seen health care savings for each dollar invested. Coors Brewing Company reported savings of up to $8.00 and General Mills saw a return of over $3.00 for each dollar invested.[56]

55 Faulkner, Lydia. Managing Health Care Costs: Lessons from the Private Sector. National Governors Association. October 2002.
56 Ibid.

PART 3: CONTRIBUTING FACTORS TO HIGHER COSTS

So far, this paper has listed several interventions in the federal and private sector that attempted to control costs primarily by shifting who pays for health insurance and health care. In some cases, costs were reduced by actively pursuing programs that promoted better health and less risk. An underlying assumption of this paper, however, is that long term costs will not be reduced by simply shifting *who* pays for health care. Rather, fundamental reform is needed in *what* is being paid for because the health care delivery system is riddled with problems and inefficiency, which directly lead to higher costs for health care and health insurance. Below is a selected list of these major factors contributing to spiraling health care costs.

1. **Prevention issues:** The unhealthy lifestyles of many Americans contribute to their increased risk for disease and higher health care costs. Tobacco use, alcohol abuse, missed immunizations, and poor nutrition increase risk and place unnecessary burdens on the health care system. Consider the following examples**:**

   Tobacco Use

   - According to the National Institute on Drug Abuse (NIDA), costs of smoking are estimated to be $138 billion per year nationwide including both direct and indirect medical costs.[57] Even for non-smokers there are additional costs including about 50,000 deaths each year in the United States attributed to second hand smoke. Second-hand tobacco smoke costs the U.S. economy more than $10 billion a year (including $5 billion in estimated medical costs and $4.6 billion in lost wages). Second-hand smoke is associated with several health risks including respiratory problems, cancer, heart disease, and poor pregnancy outcomes.[58]

57 U.S. Department of Health and Human Services. Prevention Makes Common Cents. September 2003.
58 Society of Actuaries. Economic Effects of Environmental Tobacco Smoke. 2005.

- Mothers who smoke account for: "Twenty percent of all low birth weight babies, 8 percent of preterm births, and 5 percent of all perinatal deaths."[59] Smoking during pregnancy costs an estimated $1.4 billion to $2 billion annually.
- For the first time in 70 years the annual number of cancer deaths in the United States has declined. Much of this is attributed to declines in smoking rates along with improved diagnostic tests and more effective treatment.[60] In March 2005, Medicare announced that it would immediately begin coverage of smoking cessation programs. Data has yet to be compiled on the success of Medicare coverage for these programs.

Alcohol and Drug Abuse

- The economic costs of alcohol abuse due to lost earnings, medical services and premature deaths are estimated to be $184.6 billion in per year.[61]
- The Safe and Drug Free Schools program is the primary source of funding for the majority of our nation's school-based drug and violence prevention and intervention infrastructure. It is currently used by 97 percent of the nation's school districts and serves more than 37 million youth per year. Over the past few years there has been a decrease of 25 percent in the use of illicit drugs among students in grades 6 though 12.[62] Drug abuse among youth, however, remains a major concern.
- Approximately 30 percent of youth ages 12-20 use alcohol. Alcohol use is a leading contributor to automobile accidents, murder, and date rape.[63]

59 NGA Center for Best Practices. Issue Brief. Preventing Maternal Smoking. July 2001.
60 National Center for Health Statistics. American Cancer Society. 2005.
61 Harwood, H. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods, and Data. Report prepared by The Lewin Group for the National Institute on Alcohol Abuse and Alcoholism. 2000.
62 Substance Abuse and Mental Health Services Administration. National Survey on Drug Use. 2002.
63 Substance Abuse and Mental Health Services Administration. 2003 National Survey on Drug Use & Health: Results. September 2004.

Immunizations

- Vaccinations save more than $52 billion in total health care costs and 33,000 children's lives annually.[64] Approximately 25 percent of children do not receive all five immunizations on time.[65]
- Congress created the Vaccine for Children program, which purchases vaccines from manufactures in bulk, including $40 million in 2005 for the flu vaccine, and then provides the vaccines free of charge to public clinics and registered private providers who immunize millions of American children each year. Vaccines provided through the program represent 40 percent of all childhood vaccines purchased in the U.S. Eligible individuals include children in families on Medicaid, the uninsured, American Indian or Alaska Natives, and the underinsured. In addition, the Immunization Grant Program or the Section 317 program of the Centers for Disease Control provided $479 million in 2005 discretionary federal grants to state, local, and territorial public health agencies for program operations and vaccine purchases.

2. **Infections:** Infections acquired in health care setting are a major contributor to health care expenses. Healthcare-acquired infections lead to 90,000 American deaths each year[66] and *$50 billion* in annual medical costs.[67] Infections result from poor adherence by health care staff and visitors to basic hygiene techniques such as hand-washing and clean equipment. Infections have been tracked to medical equipment such as catheters and stethoscopes, commonly used items such as pens and medical charts, and room supplies such as the remote controls for televisions. Some patients are at greater risk for these infections, especially those taking immunosuppressive drugs. However, when hospitals adhere to strict patient safety measures, they are able to

64 Orenstein, Walter. Comparison of the 20th Century Annual Morbidity and Current Morbidity, Vaccine-Preventable Diseases. The Centers for Disease Control. 2003.
65 Commonwealth Fund. Quality of Healthcare for Children and Adolescents. April 15, 2004
66 Centers for Disease Control. CDC Advisory Committee Offers Guidance to States on Developing Systems for Public Reporting of Healthcare-Associated Infections. February 2005.
67 Pennsylvania Health Care Cost Containment Council. PHC4 Research Brief - Hospital-Acquired Infections in Pennsylvania. July 13, 2005: Data Show Scourge of Hospital Infections. Washington Post. 2005.

dramatically reduce the incidence of central line, methicillin-resistant Staphylococcus aureus (MRSA), pneumonia, and urinary tract infections.

A November 2005 study by the Pennsylvania Health Care Cost Containment Council found:

"The federal Medicare Program and Pennsylvania's Medicaid programs were billed for 76 percent of the 11,668 healthcare-acquired infections reported by Pennsylvania hospitals in 2004."[68] Taxpayers in Pennsylvania consequently paid "for $1 billion in additional hospital charges for Medicare patients and $372 million in additional hospital charges for Medicaid recipients." [69] The average charges for Medicare patients with a listed healthcare acquired infection "with complications were about $160,000, compared to $32,000 for Medicare patients who did not contract an infection. For Medicaid patients, the average charges were approximately $391,000 for patients who contracted an infection while hospitalized compared to an average of $29,700 where an infection did not occur." [70] "For private insurance, the average payment cost to treat a Pennsylvania hospital patient who developed an infection was $29,000, compared with $8,300 for those who did not."[71]

A July 2005 study showed that Pennsylvanian's who contracted infections during a hospital stay in 2004 cost the state an extra $2 billion in care and caused at least 1,500 preventable deaths.[72] If one extrapolates this data with the assumption that Pennsylvania rates are similar to other parts of the country, this translates to a $20 billion dollar charge to Medicare for pay for health care acquired infections during 2004. New Pennsylvania data released in March 2006 reveals "during the first nine

68 Pennsylvania Health Care Containment Council. PHC4 Research Brief - Reducing Hospital-acquired Infections: The Business Case. November 17, 2005. March 29, 2006.: Connolly, Cici. Data Show Scourge of Hospital Infections. Washington Post. 2005.
69 Ibid.
70 Pennsylvania Health Care Containment Council. PHC4 Research Brief - Reducing Hospital-acquired Infections: The Business Case. November 17, 2005. March 29, 2006.: Connolly, Cici. Data Show Scourge of Hospital Infections. Washington Post. 2005.
71 Pennsylvania Health Care Cost Containment Council. PHC4 Research Breif - Hospital-acquired Infections in Pennsylvania. July 13, 2005.
72 Ibid.

months of 2005, hospitals identified 13,711 preventable infections, compared to 11,668 for 12 months of 2004."[73] These infections have been blamed for approximately "1,456 additional deaths, 227,000 additional hospital days, and $2.3 billion in additional hospital charges."[74]

3. **Care for the Uninsured and Underinsured:** When families have no health care "home" they forgo regular check ups and during illness they seek care at Emergency Rooms. All of these actions add to the cost of individual health care.

Emergency care

- Emergency Departments (EDs) are designed for true emergencies such as accident trauma, heart attacks, strokes, severe illness and other problems requiring life saving medical intervention.
- Many come to EDs for non-emergency care, with problems that could be handled in the office of a primary care doctor or clinic. However, federal law mandates that emergency departments must provide care to anyone who seeks it regardless of whether or not there are less expensive alternatives available for care.
- Nationwide annual non-emergency care in EDs is $4 billion. Nearly 11 percent of emergency room visits were for non-urgent care, however, the numbers vary by hospital and region.[75]
- For example, a Georgia hospital reported, 29 percent of emergency department patients sought care for common non-emergency illnesses such as ear infections and the flu at a cost of $5.6 million.[76]
- The recently passed Deficit Reduction Act lets states enforce a $3 co-payment for non-emergency care for Medicaid in order to encourage patients to seek non-emergency care at other clinics. The act also allows states to set up transportation programs for patients to receive care at alternative sites such as Community Health Centers.

73 Pennsylvania Health Care Cost Containment Council. PHC4 Research Brief - Numbers Rise As Data Submission Improves, Additional Insurance Payments Could Total $613.7 Million. March 2006.
74 Ibid.
75 National Center for Health Statistics. National Hospital Ambulatory Medical Survey: 2000. April 2002.
76 U.S. House Energy and Commerce Committee. Reforms will Rescue Medicaid. November 18, 2005.

Primary and Preventive Care

- The uninsured and underinsured often have no health care home where they can seek primary care, non-emergency care and prevention services. Community Health Centers (CHCs) provide a medical home where they are charged on a sliding fee scale for care rather than monthly health insurance.
- CHC's care often includes a wide range of services including: primary and preventive care, prenatal care, psychological services, podiatry, and dentistry.
- Community Health Centers provide less costly care, saving approximately 30 percent for Medicaid cases, yielding an annual savings of $17 billion.[77]
- Approximately 15 million seek their care at Community Health Centers; however, millions more do not have access to these centers. Applications to expand the number of CHC's can typically take 6 months to a year. Currently less than 25 percent of new applicants for CHC's are actually funded through the Health Resources and Services Administration of the U.S. Department of Health and Human Services.[78]

4. **Transparency, Quality and Cost:** Unlike most consumer markets, little information is available about price and quality in the $2 trillion American health care industry.[79] Consumers can shop around for price and quality information for everything from apples to appliances to computers and cars. It's another story when consumers attempt to get accurate quality and cost information on heart surgery, dialysis or physical therapy. As more consumers feel empowered to make their own health care choices, they are discovering that not all health care pricing, services and quality information is readily available.

77 National Association of Community Health Centers. Nation's Health At Risk II, Special Topics Issue Brief #7. August 2004. : Flores G, Abreu M, Chaisson CE, and Sun D. Keeping Children Out of Hospitals: Parents' and Physicians Perspectives on How Pediatric Hospitalizations for Ambulatory Care-Sensitive Conditions Can Be Avoided. Pediatrics 112. November 2003.
78 Bilirakis, Michael. Letter to Chairman Ralph Regula and Ranking Member David Obey RE: Funding for Community Health Centers. April 2006.
79 Borger, Christine. Health Spending Projections Through 2015: Changes On The Horizon. Health Affairs. February 28, 2006.

- Health care consumers may be given choices by insurance companies with little sense of who is the right physician or specialist to see for their needs. Consumers often rely on recommendations from primary care doctors and friends, but the information may be coming from other than objective sources. Internet sites are beginning to provide more detailed background information regarding hospitals, experience rates specific procedures/surgeries, physician qualifications, etc. However, participation in information access is voluntary and not universal.
- The vast majority of patients have little idea what procedures really cost. Wide discrepancies in health care costs are apparent. For example, two Florida medical centers charge dramatically different rates for the same cranial tap procedure ($917 vs. $5,132). Further, there are major differences in the numbers of procedures performed each year at the two centers (1,232 vs. 40 respectively).[80]
- Hospital bills are often difficult to understand. Large charges may appear on the bill for common medications such as Aspirin or Tylenol. Patients may find it difficult to review bills to determine if the charges accurately reflect what procedures were actually performed. Further information, if available, could help fight fraud.
- Health information is becoming more readily available via the internet for consumers seeking further information on disease prevention and management. Some insurance plans, hospitals and doctor's offices have their own web sites or provide an on call email service to answer patient questions. Such services are voluntary and not universally available.
- Transparency and access to information is important for all consumers but particularly for those who carry HSA insurance where they manage much of their own care decisions. It is also important for those who wish to take a more active role in their own health care management including prevention and treatment.
- In March, the Bush administration released the "Payer Power plan," to disclose price and quality data from health care providers. Plans are underway for a government review of price and quality information access for Medicaid, Medicare, U.S. Department of Defense and the Federal Employee Health Benefits

80 Gingrich, Newt. Sticker Shock Could Help with Healthcare Costs. The Hill. March 8, 2006.

program. HHS is also working with large employers to influence health care providers to make price and quality information available for 20 of the most common medical procedures.[81] Currently, the federal government only makes available a limited amount of consumer information regarding the quality of hospitals on treatment for heart attack, surgical infection prevention and pneumonia on the CMS website Hospitalcompare.hhs.gov .

5. Incomplete and disconnected medical records: Voluminous paper medical records are frequently scattered between multiple hospitals and doctors' offices resulting in the likelihood that important records could be lost or not retrieved when doctors need to be making informed decisions.

- When a patient travels, should they require emergency care, their records generally are not readily accessible adding to complications if there are significant factors in their medical history that would impact upon care decisions. Avoidable complications also occur when the patient sees multiple doctors, or even when a patient has been seen in different departments of the same hospitals.
- One study found that one in seven medical records was missing vital patient information.[82]
- Doctors often have limited time to review records during routine health care and especially during emergency care. Vital information could be overlooked.
- The paper-based, often incomplete, medical record-keeping system used by most health care providers leads to redundant tests, medical errors, and misdiagnoses. The RAND Corporation reported these critical errors add $162 billion in health care costs per year.[83]
- Medication errors such as duplicate prescriptions, allergic reactions, and adverse drug effects can also result when doctors cannot access records scattered in different locations. For instance, doctors may prescribe a medication the patient

81 Kaiser Family Foundation. *CQ HealthBeat* Examines Bush Administration Plan To Improve Price Transparency; HealthGrades Offers Price Reports for a Fee. March 20, 2006.
82 Smith, Peter. Et. al. Missing Clinical Information During Primary Care Visits. The Journal of the American Medical Association. February 2005.
83 Hillestad, Richard. Et. Al. Rand Corporation. Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs. Health Affairs. September/October 2005.

already takes, or one that interferes with another. Also, drug-to-drug interactions can counteract effectiveness, causing major complications or death.

- Errors can also occur when a physician writes a prescription with a dosage level that is too high or too low for the patient's age, weight, or sex. Other errors can occur when a drug is misspelled and appears as another prescription drug, when decimal points are miswritten, or when a doctor's handwriting is not legible. Pharmacists often call physicians to verify prescriptions, occurring 150 million times per year[84] at a cost of $4 per call. Although this verification is an added expense, and it does catch many errors, it does not catch them all. When a patient sees multiple doctors or pharmacists, the risk of errors increases.
- Medication errors cost over $29 billion dollars a year in health care to the elderly.[85]
- Many hospitals, clinics and physician practices are installing electronic medical records. However, they often use different systems and therefore cannot communicate with each other. Unified standards are needed in order for the systems to be "interoperable."
- The Medicare Modernization Act called for the U.S. Secretary of Health and Human to establish standards for electronic prescribing. In January 2006, HHS Secretary Michael Leavitt announced the launch of four cooperative agreements between health care providers and universities totaling nearly $6 million to run a pilot project throughout 2006 to test these initial standards for electronic prescribing.

6. Chronic Disease: Treatment of chronic conditions consumes nearly 80 percent of the health care costs in the United States. A complex chronic disease case requires coordination of treatments, medications and health measures to ensure patients receive appropriate care. Treatment of a patient with diabetes, for example, also requires care management, as do many other co-occurring diseases that affect vision, circulation, kidney function, digestion, heart disease, and stroke, just to name a few. Treatment is

84 Institute for Safe Medication Practices. Electronic Prescribing Can Reduce Medication Errors. 2000.
85 Center for Information Technology Leadership: EHealth Initiative. Electronic Prescribing: Toward Maximum Value and Rapid Adoption. 2004.

complex and confusing for a patient who may see literally dozens of providers for treatment and tests. The annual direct medical costs of the following chronic conditions: Diabetes: $44 billion; Arthritis: $22 billion; Cardiovascular disease (Heart Disease and Stroke): $300 billion; Depression: $12.4 billion; and Asthma: $5.1 billion.[86]

Given that doctors have limited time to speak with patients, a patient may not fully comprehend all they hear, and later will remember even less, it is no wonder that full compliance with health treatment plans is nearly impossible.

As a result, many new symptoms appear, old symptoms worsen leading to more tests, further treatments, and rehospitalization.

But much of this could have been prevented with care management.

- Care management is the practice of providing ongoing patient education and monitoring the patients status and compliance with tests and treatments. Often provided by nurses or trained medical case-workers, the management can range from checking to see if a patient picked up their medication, to carefully educating a patient on their diet, to encouraging maintenance of physical exercise programs, to reminding of medical appointments. Unfortunately, many insurance carriers do not reimburse for the care management. The University of Pittsburgh Medical Center reported that care management can reduce rehospitalizations of diabetics by as much as 75 percent. The Washington Hospital in Washington, Pennsylvania reduced rehospitalizations of patients with heart disease by 50 percent. By changing our approach to managing complex illness, billions of dollars can be saved each year.
- CMS in a February 2004 letter announced it would *match* state costs of running disease management (patient care management) programs aimed at improving health outcomes while lowering the medical costs associated with chronic diseases. In addition, the new MMA establishes two new programs, the Voluntary

86 American Medical Association. Management of Chronic Disease. Report 11 of the Council on Scientific Affairs (A-04) Full Text. June 2004.

Chronic Care Improvement Program and the Care Management Performance pilot program to further explore the potential of disease management techniques. Data on the effectiveness of these programs is still pending. The President's FY 07 budget request also includes $500 million annually for which states will compete to fund innovative ways to promote affordable insurance among the chronically ill.

7. **Barriers to mental health care:** About one in four people will suffer from a diagnosable mental disorder in their lifetime.[87] Mental illness includes a wide range of mood, behavior and thought disorders such as depression, schizophrenia, anxiety disorders, eating disorders, attention-deficit hyperactivity disorders, autism, and Alzheimer's disease. Mental illness is neither an imaginary illness nor a sign of weakness. It is a real problem with complex roots in neurobiology and environmental stresses.
    - The annual cost of untreated mental illness according to the National Institute of Health is $300 billion. This includes $150 billion from lost work days and premature death, $70 billion in emergency care and $80 billion from societal costs such as the criminal justice system.[88]
    - Untreated depression costs employers more than $51 billion per year in absenteeism and lost productivity in addition to medical and pharmaceutical costs.[89]
    - Clinical depression affects about 16 percent of the population at some point in their lifetime.[90] Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent, biologically based and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health.[91]
    - For many individuals with chronic medical illnesses such as asthma, arthritis, heart disease, cancer, and diabetes the incidence of depression can be ***double*** that

87 Kessler RC. Et. al. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry. June 2005.
88 American Psychiatric Association. Public Policy. May 1999.
89 RAND Research Highlights. The Societal Promise for Improving Care for Depression. 2004.
90 Bland, R.C. Epidemiology of Affective Disorders: A Review. Journal of Psychiatry. 1997.
91 Frank, Ellen. About Major Illness. Major Depression. NAMI. 2003.

of the general population.[92] In addition, ***untreated*** depression doubles health care costs by complicating symptoms and treatment adherence for back pain, headache and heart disease. As a result, patients with chronic medical illness and untreated depression have higher health care costs in several categories of care (primary care, medical specialty, medical inpatient and pharmacy and laboratory costs) when compared to those with chronic medical illness with treated or no depression.[93]

- Treatment for mental illness is complicated by the fact that medication is typically not prescribed by a psychiatrist. In fact, psychiatric medications are prescribed by non-psychiatrists 75 percent of the time, most frequently by primary care, general, and family physicians with little or no training in treating psychological disorders.[94] Although medication alone helps to treat depression, the combined use of medication and psychotherapy repeatedly has been shown to be far more effective and with more lasting results.
- When the care of medical and mental disorders is not integrated, there is no communication nor coordination of care between, for example, the cardiologist treating the heart and the psychiatrist treating the depression. Without integrating care, the actual cost of treatment may be higher than having the two specialists act together. Typically, insurance plans do not demand integrated care nor even require treatment of mental illness. Without integrating medical and psychological care, the system is wasting billions of dollars.
- H.R. 1402, the Mental Health Equitable Treatment Act of 2005 is one approach to fix this barrier to mental health benefits. Although it has 225 bipartisan cosponsors, it has yet to receive a vote on the House floor.
- Seniors using Medicare currently have a 50 percent co-payment for most outpatient mental health services, compared with only a 20 percent co-payment for most other outpatient services. Since depression is a common disorder among

92 Chapman. Daniel. The Vital Link Between Chronic Disease and Depressive Disorders. Centers for Disease Control. January 2005.
93 Simon GE. Et. al. Health care costs of primary care patients with recognized depression. Archives General Psychiatry. 1995.
94 Abboud, Leslie. More Family Doctors prescribe antipsychotic drugs. The Wall Street Journal. March 24, 2004.

seniors, affecting 20 percent of the elderly population this inequity may adversely affect the elderly's ability to seek needed care when mental illness occurs alone or in conjunction with other chronic illnesses.[95] H.R. 1152, the Medicare Mental Health Copayment Equity Act of 2005 would phase out these higher co-payments by 2011.

8. Defensive medicine: Defensive medicine is the practice of ordering extra tests and procedures that have little additional medical benefit, but are performed primarily to reduce liability risk. Defensive medicine costs between $60-$108 billion per year overall. The federal government share is between $23.66-42.59 billion per year.[96] In one study, ninety percent of doctors admit to performing procedures and tests to avoid liability risk that did not directly benefit the patient.[97]

- Because of defensive medicine:
  - 43 percent of doctors use imaging technology in clinically unnecessary circumstances;
  - More than 50 percent of doctors refer patients to other specialists in unnecessary circumstances;
  - 70 percent of emergency physicians order additional diagnostic tests;
  - 1/3 report prescribing more medications than were medically required;
  - 60 percent, except for neurosurgery, using unwarranted invasive procedures; and
  - 42 percent have taken steps to restrict their practice including eliminating procedures such as trauma surgery and avoiding patients who had complex medical problems.[98]
- Medical liability insurance varies according to the specialty. Emergency room physicians, neurosurgeons, obstetricians and orthopedic surgeons tend to have higher insurance costs.

95 Satcher, David. U.S. Surgeon General. Mental Health: Report of the Surgeon General 1999.
96 U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System. July 2002.
97 Studdert. David. Et.al. Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. Journal of the American Medical Association. June 1, 2005.
98 Ibid.

- Insurance rates tend to be significantly higher in states where there are no medical liability caps on punitive damages, states that permit joint liability instead of proportional liability and/or permit change of venue to counties or cities that give higher settlements for medical liability cases. For example, "in Pennsylvania, New York, New Jersey, West Virginia and Florida, defensive medicine adds from $320-$536 per year per person in extra health care spending." "In California," on the other hand, has caps on awards and "the average cost per person is $182."[99]
- States with no caps on punitive damages are concerned that more and more physicians are leaving their states or limiting the scope of their practice. In Pennsylvania for example, which does not have caps on punitive damages, full time doctors have decreased by 4,500 over 7 years and only 3.4 percent of doctors are younger than 35.[100] The situation will worsen when the current group of physicians begins to retire. Although some groups have claimed the doctor patient ratio is still adequate to meet the needs of the population, those numbers include licensed physicians who are semi-retired or have limited their practice, and new physicians with little experience.

In June 2005, for the third time the U.S. House of Representatives passed legislation to lower medical liability costs and defensive medicine by limiting noneconomic damages on junk lawsuits to $250,000 (H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act). The Senate has yet to take up this bill for a vote.

9. Cost of Prescription Drugs: Prescription drugs are an essential lifesaving and treatment tool in medicine. Proper use of medication can reduce health care spending by $100 billion annually through reduced hospitalizations and physician visits.[101] When patients cannot afford their prescription drugs, they seek out discount offers, divide their drugs, and delay or skip taking their medicines entirely. In addition to increases in

99 American College of Surgeons: Tillinghast Tort Cost Trends 2000 Report, NORCAL Mutual Insurance. February 4, 2003.
100 Pennsylvania Medical Society. The State of Medicine in Pennsylvania 2005. April 2006.
101 Medication Digest. Compliance-Adherence-Persistence. American Pharmacists Association. 2003.

individual spending, total spending by government and private programs has climbed markedly in recent years.

- In 2003 total prescription drug spending by Medicare and Medicaid reached $179.2 billion. From 1994 through 2004 prescription drug prices have increased over 8 percent per year at triple the inflation rate. This represents a four fold increase since 1990 ($40.3 billion).[60]
- Although medications prevent and treat illnesses and also save lives and money, many who cannot afford the medication reduce or alter or do not take their medication in an attempt to save money. Three main factors drive increases in prescription drug spending: increasing numbers of prescriptions (utilization), price increases, and changes in the types of drugs used.
    - Utilization: Prescription drug usage has increased 68 percent from 1994 to 2004. During that same time U.S. population grew by only 12 percent.[102] Sixty one percent of those under age 65 take prescription drugs, compared to 91 percent of those over age 65.[103]
    - Price increases: One study found that, over the 12-month period ending March 2005, manufacturers raised prices for 195 brand-name drugs most commonly used by older Americans by more than 6 percent compared to price increases on 75 generic drugs by less than 1 percent.[104] Recent studies indicate that prescription drug price increases have been lower than overall medical cost increases since passage of the new Medicare law rising only 4 percent between November 2003 and December 2004. This rise is similar to the rate of inflation seen overall in medical costs.[105]
    - Changes in Types of Drugs Used: Overall costs increases are influenced by spikes in usage of new blockbuster drugs that become very popular in treating

102 KFF calculations using data from IMS Health at www.imshealth.com and Census Bureau at http;//www.census.gov. The number of prescriptions per capita (12.0 in 2004) differs from that at http://www.statehealthfacts.kff.org (10.7 in 2003) because the data come from different sources (IMS Health vs. Verispan).

103 Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002 Compendium of Tables – Household Medical Expenditures, at http://www.meps.ahrq.gov/MEPSNet/TC/TC15.asp?File=HCFY2002&Table=HCFY2002_PLEXP.

104 AARP. Average Price Increase of Brand-Name Drugs More Than Doubles CPI. July 2005.

105 Kaiser Family Foundation. PhRMA Criticizes AARP Study Showing Average 7.1% Increase in Drug Wholesale Prices. April 13, 2005.

common ailments, such as high cholesterol, arthritis, depression or pain relief. One study found that just 50 drugs, out of a total of 9,482 on the retail market, were responsible for 62.3 percent of the $22.5 billion increase in prescription drug spending in 2001. Sales of these 50 drugs rose 34.3 percent in 2001 compared to a 9.3 increase for all other drugs[106]

When one factors in the total cost of research for drugs, it is important to include not only those that do have a therapeutic value, but also those that never make it to market. That total cost has increased from $231 million in 1987 to $802 million in 2000.[107] Drug manufacturers cite the high research and development costs as a primary reason for the price of prescription drugs. The total amount spent for medication R&D has increased from $13.4 billion (17.3 percent of sales) in 1994 to $38.8 billion (15.9 percent of sales) in 2004.[108]

Paying for medication

Employer-sponsored health plans have responded to increasing prescription drug costs by establishing tiered cost-sharing formulas based on income and increasing drug co-payments. Currently, about 76 percent of employer sponsored plans require cost sharing. Compare this to only 27 percent requiring cost sharing five years ago in 2000. The dollar amount of required co-payments has also doubled from $17 to $35. Even when a formulary list is used, the co-payment amount has increased nearly 70 percent in the past 5 years.[109]

106 National Institute for Health Care Management Research and Educational Foundation. Prescription Drugs and Mass Media Advertising, 2000.: CNNMoney: Prescription Drug spending up 17%. March 29, 2002.

107 DiMasi, JA. Et. al. The price of Innovation: New Estimates of Drug Development Costs. Journal of Health Economics. 2003: Food and Drug Administration Progress and Priorities 2004. Protecting and Advancing America's Health. September 2004.

108 Pharmaceutical Research and Manufacturers of America. Pharmaceutical Industry Profile, various years. Available at http://www.phrma.org/publications. Reflects data from PhRMA members only (approx. 80% of total R&D in 2004).

109 Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2005 Annual Survey, September 2005. Available at: http://www.kff.org/insurance/7315/exhibits/index.cfm.

Free and discount drug programs

Pharmaceutical companies are offering free and discounted prescription drugs to individuals with low incomes who lack health insurance or patients with chronic illnesses through Prescription Assistance Programs (PAPs). PAPs are allowed to provide coverage for specific drugs but, unfortunately, PAPs cannot be used to assist Medicare Part D patients with their deductibles and out-of-pocket expenses. This has forced many successful programs such as GlaxoSmithKline's (GSK) PAP, which provided over $372 million in free medicines to more than 475,000 individuals to cancel its program. However, Merck, Pfizer and 10 other companies continues to offer discounts of up to 25–40 percent on over 275 brand-name prescription drugs for individuals with annual incomes below $30,000 or below $60,000 for a family of four.

Drug Re-importation

Several bills have been introduced in recent years to permit prescription drugs to be re-imported into the United States in an attempt to provide lower cost options. Several stories emerged in the past few years of bus trips to Canada to obtain cheaper drugs. Many web sites have merged that offer discount drugs from other countries around the world. Some states have tried to permit re-imported drugs as part of their prescription benefits programs. Critics have responded by saying that Canada's lower costs are due to price controls, formularies, and restrictions on the availability of some medications. The medications may be expired or counterfeit and the discounts may not be as dramatic as some initially claimed.

- Generics tend to cost less in the USA than they do in Canada.
- The CBO concluded that permitting re-importation would reduce drug spending by only 1 percent.[110]
- A report from AARP concluded the Medicare Part D program provided greater drug discounts than could be obtained if purchasing drugs from Canada[111]

110 AARP. The New Math: Cheaper than Canada? January 2006.
111 Ibid.

- "The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 permits re-importation of prescription drugs from Canada if the Secretary of HHS certifies both their safety and cost savings. To date, the Secretary has not provided that certification."[112]

Counterfeit Drugs

Counterfeit drugs have emerged from multiple market sources that are sold under a product name without proper authorization and may contain incorrect, improper or hazardous ingredients. The FDA has warned that the quality and safety of imported drugs cannot be guaranteed and that patients choosing to use those products face elevated health risks such as allergic reactions, drug-drug interactions, infections, poisoning, a worsening of their medical condition, and death.

- FDA only has information on 18 percent of the foreign drug manufacturers shipping to the U.S.[113]
- A number of counterfeits do not contain any active ingredients and thus provide no treatment benefit to the patient.
- A shipment of Procrit, used to treat cancer was seized at a port in Florida. Analysis of its content revealed it contained non-sterile water.
- A seized shipment of Zyprexa, used to treat schizophrenia, contained nothing more than white pills marked "aspirin". Not only did it risk the return or worsening of severe mental illness symptoms, but it could have created life threatening reactions for patients allergic to aspirin.[114]

The cost of medication is having a major impact not only on the family budget but also on the U.S. budget. Without access to affordable medication, however, many medical conditions worsen, adding to health care costs in other areas. Dealing with

112 Congressional Budget Office. Would Prescription Drug Importation Reduce U.S. Drug Spending. Economic and Budget Issue Brief. April 19, 2004.
113 Hubbard, William. Associate Commissioner for Policy and Planning, Testimony. U.S. Food and Drug Administration. U.S. Department of Health and Human Service. December 2000: CBS News. Counterfeit Drugs: Rx for Danger. December 8, 2000.
114 Food and Drug Administration. FDA's Counterfeit Drug Task Force Interim Report. U.S. Department of Health and Human Services. March 2003.

the cost of prescription drugs, therefore can only be properly addressed in the context of the overall costs of health care.

10. **Obesity:** Obesity rates are increasing among adults and children. The proportion of children and adolescents who are overweight has tripled in the past 3 decades.[115] Each year, $75 billion is spent nationwide on obesity-related medical expenditures. Medicare and Medicaid finance approximately one-half of these expenditures, private insurance pays the other half.[116] Obesity raises the risk for over 20 medical conditions including type 2 diabetes, arthritis, heart disease and a variety of cancers by increasing fat deposits, weakening immune systems, and reducing mobility. The following afflictions can be brought about or exacerbated by obesity:

    - ✓ Heart Disease: Nationwide annual expenses for treating heart disease associated with obesity is $30.6 billion.[117] Risk for high blood pressure doubles with obesity.[118] In 2002, 28 percent of American adults have two or more heart disease risk factors such as high cholesterol, obesity, diabetes, smoking, and inactivity. In 1991 the risk factors were seen in 24 percent of the population.[119]
    - ✓ Diabetes: $20.5 billion is spent annually nationwide treating diabetes in obese patients.[120] A weight gain of only 11 to 18 pounds can double the risk of developing type 2 diabetes.[121]
    - ✓ Cancer: A weight gain of 20 pounds in women from age 18 to midlife doubles the risk of postmenopausal breast cancer.[122]

115 Yanovski, Jack. Treatment of Pediatric and Adolescent Obesity. JAMA. April 2003.
116 Finkelstein, Eric. Et al. State-Level Estimates of Annual Medical Expenditures Attributable to Obesity. Centers for Disease Control. Obesity Research. 2004.
117 U.S. Department of Health and Human Services. Prevention Makes Common Cents. 2003
118 U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. 2005.
119 American Heart Association. Heart Disease and Stroke Statistics — 2005 Update.
120 U.S. Department of Health and Human Services. Prevention Makes Common Cents. 2003
121 U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. 2005.
122 Ibid.

- ✓ Arthritis: $7.4 billion is spent annually nationwide treating arthritis in obese patient.[123] Arthritis risk increases by 9 percent to 13 percent for every 2-pound increase in weight.[124]
- ✓ Infant mortality: Obesity can lead to an increased mortality risk in both the baby and the mother. It can also increase the risk of maternal high blood pressure by 10 times.[125]

- 38.6 percent of American adults report no leisure-time physical activity.[126]
- Despite awareness for the health benefits of regular exercise, there has been a steady and dramatic decline in the number of high schools requiring physical education classes. While 94.1 percent of states and 95 percent of districts are required to offer physical education, only 19.6 percent of states and 12.3 percent of districts specify that students may *not* be exempted or excused from physical education.[127] Only Illinois requires public school students to take physical education classes from to 12th grade. Less than two thirds (60 percent) of high school students are enrolled in physical education classes, and only 25 percent take physical education daily. [128]
- The President's Council on Physical Fitness and Sports has begun the President's Challenge to promote an active lifestyle of physical activity for 30 minutes a day/5 days a week (or 60 minutes a day for youths under 18). The Carol White Physical Education program of the U.S. Department of Education, provided over $69 million in grants in FY 2004 to develop physical education programs to help K-12 students make progress toward meeting state standards for physical education.
- For severely obese beneficiaries Medicare expanded its coverage of weight-loss surgery with limitations. Seniors must have tried other treatments without success

123 U.S. Department of Health and Human Services. Prevention Makes Common Cents. 2003
124 Ibid.
125 U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. 2005.
126American Heart Association. Heart Disease and Stroke Statistics – 2005. 2003.
127 Pate, Russell. Et. al. School Physical Education. National School Boards Association. Journal of School Health. 1995.
128 Centers for Disease Control and Prevention. Guidelines for school and community programs: Promoting lifelong physical activity. Morbidity and Mortality Weekly Report. 1997.

and have at least one health condition related to obesity. Medicaid does not cover obesity treatments.

- In February 2006, the Veterans Affairs and Health and Human Services departments launched a campaign to promote nutrition, exercise, education, preventive medicine and weight loss. VA doctors will give out “prescriptions for health” to obese patients with a list of exercises and nutritional information that match patients' health needs. The VA will also begin “Fit for Life Volunteer Corps," a group of veterans who practice healthy lifestyles as an example to others.[129]
- For 2004, the Office of Personal Management (OPM) announced the *HealthierFeds* campaign to educate federal employees and to determine federal benchmarks of the health care benefits from improvements in physical activity, nutrition, and behavior.
- The National School Lunch Program administered by the U.S. Department of Agriculture provides over $7 billion for 99,800 school children each school day. To be eligible for free meals, children must come from families below 130 percent of the poverty level ($12,000). School lunches must meet Dietary Guidelines for Americans with no more than 30 percent of an individual's calories come from fat, and less than 10 percent from saturated fat. Lunches must provide one-third of the Recommended Dietary Allowances of protein, Vitamin A, Vitamin C, iron, calcium, and calories.
- Obesity concerns have sparked interest in warning labels for fast food, eliminating soft drinks and high fat content foods in schools, and restructuring the recommended daily dietary intake.
- Ironically, American’s spend vast amounts of money on unhealthy levels of food that increase weight and diet books/programs to lose the weight. In the meantime, while more adults and children are becoming obese and out of shape, it serves to further strain both present and future health care costs.

129 U.S. Department of Veterans Affairs. VA and HHS to Target Diabetes, Obesity among American Veterans. February 27, 2006.

PART 4: SOLUTIONS TO MAKE HEALTH CARE MORE AFFORDABLE AND ACCESSIBLE

In response to these areas of concern, there are several actions that if taken, could dramatically change the cost of health care. Here are ten solutions that could effectively and immediately make health care more affordable and accessible:

1. **Practice primary prevention:** Primary prevention involves efforts to reduce risk of disease before symptoms appear through the use of such actions as education, lifestyle changes, public health programs, and vaccinations. The government could provide incentives and educate businesses on the financial benefits of promoting a healthy workforce through exercise/nutrition programs and health-risk screenings.

- California's statewide tobacco prevention program resulted in an overall cost savings of $8.4 billion over eight years.[130]
- Programs offered by employers which provide health education to their employees including exercise programs, health-risk screening and appraisal, weight control, nutrition information, stress management, disease screening, and smoking cessation found a significant return on investment for these programs. These programs saved an average of $3.14 in health costs for every dollar spent.
    - Motorola's wellness program saved $3.93 for every $1 invested;
    - Northeast Utilities WellAware Program reduced lifestyle and behavioral claims by $1.4 million in its first two years;
    - Caterpillar's Healthy Balance program will save $700 million by 2015; and
    - Johnson & Johnson's Health and Wellness Program saves $224.66 per employee per year.[131]

130 California Department of Health Services Tobacco Control Section. California Tobacco Control Update. August 2000.
131 U.S. Department of Health and Human Services. Prevention makes common cents. September 2003.

Nutritional Supplements

- Nutritional supplements have been described in research studies as an inexpensive way to reduce symptoms and health risks for certain health conditions. For example, one study found that using Glucosamine and Chondroitin provided moderate to severe pain relief for arthritis.[132] Another study found that Omega-3 fatty acids lowered blood pressure to reduce the risk of cardiovascular disease.[133] The health findings uncovered during these studies were based on a certain serving size of these supplements given three times a day. The potency of nutritional supplements, however, is unregulated and can vary between different manufacturers. This makes it very difficult for consumers wishing to use nutritional supplements as part of their health program.
- Under the Dietary Supplement Health and Education Act (DSHEA) of 1994, "other than the manufacturer's responsibility to ensure safety, there are no rules that limit a serving size or the amount of a nutrient in any form of dietary supplements. This decision is made by the manufacturer and does not require FDA review or approval."[134] In addition, nutritional supplements affect everyone differently and could cause adverse events for people on certain medications. For example, "high intakes of Omega-3 fatty acids could cause excessive bleeding in some people."[135] This leads to the question of whether the DSHEA Act needs to be updated to incorporate nutritional supplements into health care treatments under the care of a doctor.
- Where there are health benefits to taking certain nutritional supplements, it is essential that the public has access to reliable and valid, scientific research.
- H.R. 2485 or the DSHEA Full Implementation and Enforcement Act has been introduced to increase funding for the FDA to enforce DSHEA and tighten product-specific enforcement by doubling the funding given to the Office of

132 Arthritis Foundation. Arthritis Foundation Statement on the Glucosamine/chondroitin Arthritis Intervention Trial. February 2006. : National Institutes of Health. National Center for Complimentary and Alternative Medicine. Background. Questions and Answers. NIH Glucosamine/chondroitin Arthritis Intervention Trial. February 2006.
133 American Heart Association. Fish and Omega 3 Fatty Acids. 2000.
134 Food and Drug Administration. Center for Food Safety and Applied Nutrition. Overview of Dietary Supplements. January 3, 2001.
135 American Heart Association. Fish and Omega 3 Fatty Acids. 2000.

Dietary Supplements to expand research and consumer information about dietary supplements. In addition, this bill would hold the FDA accountable for filing annual reports to Congress about how they are regulating dietary supplements.

Recommendation:

- The federal government could provide incentives and educate businesses on the financial benefits of promoting a healthy workforce through exercise/nutrition programs and health-risk screenings. Information could be compiled by the U.S. Department of Health and Human Services on how these avoidable conditions are major contributors to spiraling health care costs. Federal resources should be leveraged at the Department of Veterans Affairs, in Medicare and Medicaid, and at our nation's schools to promote primary prevention.
- Congress should also strengthen initiatives to educate the public on health risks, personal responsibility and solutions.
- Members can use their offices to increase public awareness of healthy lifestyle and preventive care initiatives.
- Congress should examine whether the DSHEA Act that regulates nutritional supplements needs to be updated to provide quality and potency standards.
- Studies can also be conducted to determine if nutritional supplements should be coordinated with medications under the supervision of a doctor and covered by private or federal health insurance plans.
- Congress should work with the FDA to encourage more public access to valid and reliable scientific studies to nutritional supplements regarding health benefits and/or risks.

2. Eliminate preventable infections: Several hundred hospitals around the country are finding dramatic success in reducing surgical infections by properly adhering to specific clinical guidelines and implementing patient safety procedures. For example, many hospitals are administering guidelines which dictate administering antibiotics to surgical

patients within 60 minutes before an incision is made, ensuring the correct antibiotic is given, and ending antibiotics 24 hours after surgery ends.

- Mercy Health Center in Oklahoma performed 400 surgeries without any infections.[136] A major teaching hospital in St. Louis reduced central line acquired infection rates through a mandatory educational program for all staff**.** Fact sheets and informational posters were also placed throughout the hospital. The estimated cost savings following the introduction of this educational program was between $103,600 and $1,573,000.[137]
- The VA Pittsburgh Health care system has reduced Methicillin-Resistant Staphylococcus aureus (MRSA) infections by 85 percent in an inpatient surgical unit by implementing patient safety procedures.
- Allegheny General Hospital in Pennsylvania reduced the rate of central line-acquired infections from nineteen to almost zero within 90 days and eliminated acquired blood stream infections and related deaths completely by educating and training health care staff on infection control. Hospital savings were estimated at over $2 million and 47 lives were saved. Southwestern Pennsylvania hospitals reduced central line infections by 55 percent over three years**.**[138]

Recommendation:

- As the largest payer for health care services, the federal government should work with states to set the goal of ***zero*** healthcare-acquired infections nationwide.
- Health care providers should reduce health care acquired infections with pay-for-performance incentives through Medicare and Medicaid.
- Support should also be provided for health information technology to improve reporting of health care and health care acquired infections.
- The U.S. Department of Health and Human Services should work with patient safety organizations under the authority of the Patient Safety and Quality

136 Bratzler, Dale. Use of Antimicrobial Prophylaxis for Major Surgery: Baseline Results From the National Surgical Infection Prevention Project. Archives of Surgery. 2005.
137 Warren, David. Et al. The Effect of an Education Program on the Incidence of Central Venous Catheter-Associated Bloodstream Infection in a Medical ICU. CHEST 2004.
138 Guadagnino, Christopher. Pa.'s Hospital Acquired Infection Battle. Physician's News Digest. February 2006. : Pittsburgh Regional Healthcare Initiative.

Improvement Act (Public Law 109-41) to implement best practices and to leverage reporting data to target resources to eliminate preventable infections.

3. <u>Expand Community Health Centers (CHCs):</u> CHCs are non-profit, community supported health care providers who offer primary and preventive health care services on a sliding fee schedule based to low-income, underinsured and uninsured families. Medical care at Community Health Centers is approximately $250 less than the average annual expenditure for office-based doctor visits.[139] It is important to keep in mind that over 30 percent of patients seeking care at a CHC are uninsured.[140]
CHC services save money and lives by treating diseases before they become chronic conditions or require hospital care.

- By expanding CHCs, America could save as much as 30 percent per Medicaid patient or $17 billion annually due to reduced specialty care referrals and fewer hospital admissions.[141]
- Many qualified and skilled medical professionals would be willing to volunteer their time and service to a CHC, however, they are turned away because the clinics cannot afford to cover the additional medical liability insurance. Many professionals are hesitant to volunteer their services due to the high cost of medical liability insurance. Currently, there are too few volunteer physicians—less than 100—available at our nation's 3,700 Community Health Centers. Liability protections for "good Samaritan"-volunteer doctors at Community Health Centers would allow these centers to recruit the 12,000 physicians required to staff the 300 new and expanded access sites in the FY 2007 budget request.

139 Olin GL. National Health Care Expenses in U.S. Community Population, 2000. Statistical Brief #27. 2000 Uniform Data System DHHS. DHHS. 2003.
140 Bureau of Primary Care. Uniform Data System. 2003.
141 National Association of Community Health Centers. Nation's Health At Risk II, Special Topics Issue Brief #7. August 2004.: Flores G, Abreu M. Et. al. Keeping Children Out of Hospitals: Parents' and Physicians Perspectives on How Pediatric Hospitalizations for Ambulatory Care-Sensitive Conditions Can Be Avoided. Pediatrics. November 2003.

Recommendation:

- Congress should ease the regulatory burden of four quarterly reports before providing funding for new access sites for Community Health Centers. In addition, in order to meet the President's goal of a Community Health Center in every community that can support one.
- Congress should pass legislation such as HR 1313, the Community Health Center Volunteer Physician Protection Act that permits medical liability coverage for volunteer doctors and other medical professionals at CHCs.

4. <u>Increase transparency:</u> Uniform standards for reporting health care quality and cost information will help to inform consumers in a national health care marketplace where competition and quality will lower costs. The collection of additional quality data and reporting should provide accurate, up-to-date information that is easy to read, understandable to the general public and accessible to every American health care consumer. A risk-adjustment should also be applied to any increased transparency in health care quality for providers and facilities that treat large numbers of elderly and chronic care patients, younger and healthier patients, patients with genetic predispositions or areas with high obesity and smoking rates.

Recommendation:

- Federal efforts should be made to simplify hospital billing so that consumers can easily understand their hospital bills.
- Federal incentives should also be provided to encourage the efforts of health care providers to increase health care quality and cost transparency. HSAs depend on transparency for consumers to determine the best quality and affordable care. However, consumers and the federal government could also use this information to prevent fraud and abuse in pricing for services and oversight on the quality of care for our nation's health care programs.
- A pilot program could determine if increased health care transparency efforts lower costs or improves outcomes with consumer-driven health care reforms. Congressional oversight of quality and cost data will also ensure American

health care consumers are receiving accurate information when they seek medical care.

5. **Support health information technology (Health IT):** Electronic medical records (EMRs) and electronic prescribing can reduce costly medical and medication errors, while quickly and securely being able to provide a patient's medical records and tests at a moments notice.
    - EMRs: Bringing medical records into the 21st Century by using Health IT would centralize patient information to help eliminate duplicate tests, reduce the search time for medical histories, and limit instances of lost or inaccessible files.
    - Health IT would also help doctors perform accurate diagnoses, recognize symptoms, and reduce the need for additional staff and the expansive storage space needed to maintain paper files. When medical errors occur, EMRs allow providers to retrace the exact steps through the medical procedure to see where the error occurred. EMRs also prompt providers to pursue certain avenues of treatment based on diagnosis and automatically generate bills and reimbursements which reduce billing errors. These advances can help to reduce the 195,000 preventable annual deaths due to medical errors.[142]
    - Electronic prescribing can prevent many of the deaths associated with Adverse Drug Events (ADEs) or unsafe, ineffective or inadequate use of prescription drugs.

Recommendation:

- The government should pass legislation that speeds up the process of setting standards for health IT such as H.R. 2234, the 21st Century Health Information Act that establishes regional collaborations and demonstration projects to test the effectiveness of Health IT and encourage widespread adoption of EMRs.

142 HealthGrades. Patient Safety in American Hospitals study. July 2004.

- Pilot studies can determine cost savings, monitor efficiency, and help adopt uniform health information standards to allow medical information to be stored and communicated while protecting privacy.

6. <u>Support patient care management for chronic illness:</u> A complex medical case requires coordination of treatments, medications and health measures to ensure patients receive appropriate care. Patient care management involves careful monitoring of patients to ensure patients follow through on complex treatment plans such as keeping appointments, watching diet, taking medications appropriately and following medical procedures. Previously cited data reported remarkable reductions in hospitalization rates with patients involved in care management programs.

- A Medicare comprehensive diabetes patient care management program involving more than 20 thousand seniors reduced complications and yielded savings of $1.5 million per 1,000 patients with diabetes."[143]
- An Oregon patient care management program for 11,000 Medicaid patients with diabetes, asthma and congestive heart failure saved $6 million annually in health care costs and improved outcomes dramatically.[144]
- A study of 300,000 children (under age 21) on Medicaid enrolled in a pediatric asthma management program lowered hospital admissions by 34 percent.[145]
- Pharmacist-physician care management partnerships to monitor patients' drug therapies reduces drug-related illnesses by $177 billion annually.[146]
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) will provide reimbursement to pharmacists for

143 American Healthways. American Healthways' Comprehensive Diabetes Disease Management Program Improves Health Status for Medicare Recipients and Reduces Health Care Costs by 17.1 Percent. July 2000.
144 Moody, Robin. Disease Management Saves State Health Plan Money. Portland Business Journal. April 2005.
145 NGA Center for Best Practices (2003). "Disease Management: The New Tool for Cost Containment and Quality Care," Issue Brief (Washington, DC: NGA).
146 Brian, Islet. Et. al. Quality Assessment of a Collaborative Approach for Decreasing Drug-Related Morbidity and Achieving Therapeutic Goals. Archives of Internal Medicine. 2003.

medication therapy management (MTM) programs. These programs manage and monitor patients' drug therapy for chronic conditions to ensure that seniors are taking their medicines.

Recommendation:

- Federally supported health care plans should create incentives for patient care management.
- Demonstration projects should be established to review patient care management programs.
- Congress can continue to reduce costs and save lives in federal Medicare and Medicaid spending by implementing additional patient care management programs such as Medication Therapy Management programs.
- Medicare should monitor and report to Congress cost-savings from careful adherence to medication treatment through medication therapy management programs.

7. Integrate medical and psychological health care: The U.S. must combine *medical* and *behavioral* health services to coordinate the diagnosis and treatment within the full spectrum of disease. The private sector has demonstrated direct health care cost savings as well as savings from productivity improvements. One study reported that when depression management was included in their health plans productivity increased over 6 percent and absenteeism declined 28 percent with a savings of $2,601 per each depressed employee.[147] When workers with depression receive treatment, medical costs decline by $882 per employee each year.[148] A study of integrated care for federal employees found five out of seven plans reduced out-of-pocket spending significantly.[149]

147 Rost, Kathryn, Ph.D., The Effect of Improving Primary Care Depression Management on Employee Absenteeism and Productivity. Medical Care. Pg. 1202-1210. Volume 42, Number 12, December 2004.
148 Health Economics. 2004.
149 Goldman, Howard. Et. Al. Behavioral Health Insurance Parity for Federal Employees. The New England Journal of Medicine. March 30, 2006.

Recommendation:

- Congress should pass legislation that encourages this integration and coordination of care. Two bills that seek to address this problem include:
    - H.R. 1125, the Medicare Mental Health Co-payment Equity Act to eliminate the discriminatory 50 percent co-payment for all mental health outpatient services for our nation's seniors; and
    - H.R. 1402, the Paul Wellstone Mental Health Equitable Treatment Act of 2005, which integrates medical and behavioral health care to improve outcomes.
- Congress should also encourage the use of health information technology to achieve full coordination and patient treatment of medical and behavioral health conditions, screening for mental illness under existing laws for early intervention, prevention and more accurate diagnosis and treatments to reduce medical errors must also be promoted.

8. <u>End defensive medicine:</u> Patients should review medical decisions with their doctors to eliminate unnecessary tests and procedures in order to cut the practice of defensive medicine. Federal legislation should be passed to reduce junk lawsuits. HHS estimates that reforms could lead to a 5 to 9 percent decrease in medical costs associated with defensive medicine with dollar savings between $28.1 billion to $50.6 billion.[150]

Recommendation:

- Congress needs to pass legislation which prevents junk lawsuits and massive punitive damages while still allowing avenues for redress. As one plaintiff attorney put it "the problem with medical malpractice is medical malpractice." But concerns remain that unlimited punitive damages has not prevented neglect and abuse within the medical system. Physicians in key specialties continue to leave regions where the cost of their medical

150 U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care. March 2003.

liability insurance is excessive. Regions without ready access to neurosurgeons and obstetricians increases the likelihood of harm for those who cannot access the urgent care they need. A patient in the middle of a stroke needs a doctor and a mother in the middle of labor needs a doctor immediately.

- H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Health care (HEALTH) Act has been passed three times by the U.S. House of Representatives but has not passed the U.S. Senate.
- Hospitals and medical staff need to increase their oversight, patient safety and quality control. Actions that focus on patient safety and error reduction are essential components in reducing liability costs. Information technology measures such as electronic medical records and electronic prescribing have proven valuable in reducing errors, lowering the costs of defensive medicine and saving lives.

9. <u>Lower prescription drug costs:</u> One Pharmaceutical Benefit Management (PBM) company estimates that if consumers compared prescription drug prices over the Internet it could lower costs by 40 percent.[151] Support for state public-private partnership programs to establish online cost and information models for prescription drugs in every state will lower drug costs. These models can become the basis for a national system of drug pricing information that is valuable to consumers.

- Millions of federal and state dollars could be saved by restocking unused prescription drugs that are often discarded by long-term care facilities. Restocking prescription drugs means returning unused prescription drugs to pharmacists for a refund or reuse. A Florida law establishing a restocking program in long term care facilities estimates $14.1 million in annual cost savings.[152]
- Often the expiration dates of prescription and over-the-counter drugs do not accurately reflect the true shelf life, resulting in billions of dollars wasted

151 Center for Health Transformation. Remarks by Newt Gingrich at the National Press Club. Transforming Medicaid. MedImpact. August 2005.
152 National Conference of State Legislatures. Recent Medicaid Prescription Drug Laws and Strategies, 2001-2004.

annually on discarded drugs that are potentially still potent and safe beyond their labeled expiration dates.[153] The FDA's Shelf Life Extension Program (SLEP) for the U.S. military tested over 100 prescription and over-the-counter drugs in the first year of the existence and found that over 90 percent were safe and effective far past their original expiration date, in some instances for up to 15 years. This program has saved the government $263.4 million over six years.[154]

Recommendation:

- Any existing or new state government website that provides prescription drug comparisons should be accurate, consumer friendly and easily accessible. These web pages should also contain accurate information on generic drugs
- Congress should support state public-private partnership programs to establish online cost and information models for prescription drugs in every state. These models could become the basis for a national system of drug pricing information that is valuable to consumers.
- Congress should also work with the FDA, pharmaceutical manufacturers and the U.S. military to convene a working group of scientific, medical and pharmaceutical experts to evaluate the FDA's current expiration date regulations. Congress should work with states to establish a uniform drug restocking standard that will maximize the cost savings of unused prescription drugs. Studies could provide more accurate expiration dates of prescription and over-the-counter drugs and report clinical and/or economic benefits for patients.
- By exempting Prescription Assistance Plans (PAPs) or free and discount drug programs from current-anti-kickback laws, savings from these programs could be used by seniors to dramatically lower the deductible and out-of-pocket expenses of the new Medicare Part D drug discount plan.
- Congress needs to work with the FDA and law enforcement agencies to stop drug counterfeiting. H.R. 4829, the Reducing Fraudulent and Imitation Drugs Act of 2006 provides one avenue to help reduce counterfeit drugs. This legislation

153 Cohen, Laurie. Drugs Frequently Potent Past Expiration. The Wall Street Journal. March 29, 2000.
154 Ibid.

directs the Secretary of Health and Human Services to incorporate counterfeit-resistant technologies including radio frequency identification (RFID) tagging technology, or similar trace-and-track technology into the packaging of prescription drugs.

- The use of electronic prescribing in health information technology could greatly reduce medication errors, and costs by directly saving money on medications as well as reducing hospitalizations and medical interventions.

10. <u>Reducing obesity:</u> A third of America's children are obese. Because children are now eating more unhealthy foods, and leading more sedentary lifestyles congressional committees that deal with health, education and recreation need to review ways they can work to improve the health, nutrition and the physical activity of children: parks/recreation facilities, menu at schools, health education on obesity prevention and healthy lifestyles.

Additionally, the proportion of overweight Americans ages 65 to 74 has gone from 57 percent in 1980 to 73 percent in 2002.[155] Incentives with Medicare, Medicaid and the federal employees' health benefits programs can reach major segments of the population. We can learn from the positive results achieved from efforts to reduce tobacco use and vehicular accidents. We need the same or greater emphasis on obesity issues.

Recommendation:

- Prevention starts at home. Individuals should exercise personal responsibility, eat balanced diets and healthy meals and establish an exercise routine and healthy nutrition program for their families. Vigorous public education campaigns should be implemented to promote healthy nutrition and exercise programs at schools and in the workplace to prevent the onset of these chronic diseases.
- Medicare, Medicaid, the Veterans Affairs Administration and federal employees' health insurance programs should learn from private employers such as Motorola

155 Mjoseth, Jeannine. Federal Forum Reports Americans Aging Well, But Gaps Remain. Older Americans 2004: Key Indicators of Well-Being. Federal Interagency Forum on Aging Related Statistics. November 2004.

and Johnson & Johnson to implement health promotion programs to eliminate obesity and obesity related medical expenses.

- Encourage congressional committees to hold hearings to gather information and statistics on contributors to obesity in both elderly and young populations and as a forum for recommendations for change.
- Private-public employer pilot programs for health promotion programs must contain effective measures to determine their success at reducing health care costs and improving the health of employees. Vigorous congressional oversight is required to determine the effectiveness of health promotion programs at reducing obesity to eliminate any ineffective or duplicative programs.

Conclusion: Saving Lives and Money

If America makes the preceding investments and creates the incentives required for the private sector to invest, keeping in mind these 10 principles for change, we can lower health care costs by at least *$300 billion per year*. These are concrete ways that we can make health care more affordable by bringing it back into reach for American families. By improving the quality of our nation's health care system we can ensure that families will not have to choose between food and medical coverage or put off early, necessary care to treat symptoms with "hope," instead of medicine. By transforming our nation's health care system, the federal government will be saving billions of dollars to the American taxpayer. By making health care more affordable and accessible through fundamental improvements and reforms, we can respond with compassion to the concerns of many of our families. Acting now to improve the quality of health care is quite literally a matter of life and death.